FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 8008518

Facility Name: Gottlieb Memorial Hospital

Address: 701 West North Avenue (Number) Melrose Park (City) 60160 (Zip Code)

County: Cook

Telephone Number: (708)450-4949 **Fax #** (708)681-1688

IDPA ID Number:

Date of Initial License for Current Owners: 06/10/85

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Ellyn Chin **Telephone Number:** (708)450-4534

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Andrew Knauf

(Title) Vice President, Finance

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	34	Skilled (SNF)	34	12,410	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	34	TOTALS	34	12,410	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	177		7,750	7,927	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	177		7,750	7,927	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.88%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/20/85

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 5,640

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	137,582	20,304	170,765	328,651		328,651	0	328,651			1
2	Food Purchase		15,034		15,034		15,034	0	15,034			2
3	Housekeeping	73,781	10,666	79,379	163,826		163,826	0	163,826			3
4	Laundry	13,092	23,670	64,734	101,496	0	101,496	0	101,496			4
5	Heat and Other Utilities			144,405	144,405		144,405	0	144,405			5
6	Maintenance	58,741	2,228	115,175	176,144		176,144	0	176,144			6
7	Other (specify):* Cafeteria	3,527	542	30,356	34,425	(34,425)	0	0	0			7
8	**TOTAL General Services**	286,723	72,444	604,814	963,981	(34,425)	929,556	0	929,556			8
	B. Health Care and Programs											
9	Medical Director				0		0	0	0			9
10	Nursing and Medical Records	1,345,698	41,126	178,450	1,565,274		1,565,274	0	1,565,274			10
10a	Therapy				0		0	0	0			10a
11	Activities				0		0	0	0			11
12	Social Services	50,196	264	38,355	88,815		88,815	0	88,815			12
13	Nurse Aide Training				0		0	0	0			13
14	Program Transportation				0		0	0	0			14
15	Other (specify):* CPD/Pharmacy	3,101	5,276	3,615	11,992		11,992	0	11,992			15
16	**TOTAL Health Care and Programs**	1,398,995	46,666	220,420	1,666,081	0	1,666,081	0	1,666,081			16
	C. General Administration											
17	Administrative				0		0	0	0			17
18	Directors Fees				0		0	0	0			18
19	Professional Services				0		0	0	0			19
20	Dues, Fees, Subscriptions & Promotions				0		0	0	0			20
21	Clerical & General Office Expenses				0		0	0	0			21
22	Employee Benefits & Payroll Taxes			279,688	279,688	34,425	314,113	0	314,113			22
23	Inservice Training & Education				0		0	0	0			23
24	Travel and Seminar				0		0	0	0			24
25	Other Admin. Staff Transportation				0		0	0	0			25
26	Insurance-Prop.Liab.Malpractice			54,123	54,123		54,123	0	54,123			26
27	Other (specify):*				0		0	0	0			27
28	**TOTAL General Administration**	0	0	333,811	333,811	34,425	368,236	0	368,236			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,685,718	119,110	1,159,045	2,963,873	0	2,963,873	0	2,963,873			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Gottlieb Memorial Hospital #8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			243,937	243,937		243,937	0	243,937			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			20,238	20,238		20,238	0	20,238			32
33	Real Estate Taxes				0		0	0	0			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles				0		0	0	0			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			264,175	264,175	0	264,175	0	264,175			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers			1,362,616	1,362,616		1,362,616	0	1,362,616			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee				0		0	0	0			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	0	1,362,616	1,362,616	0	1,362,616	0	1,362,616			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,685,718	119,110	2,785,836	4,590,664	0	4,590,664	0	4,590,664			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 0		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 0		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 0		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Gottlieb Memorial Hospital

ID# 8008518

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Gottlieb Memorial Hospital** **#** **8008518** **Report Period Beginning:** **01/01/01** **Ending:** **12/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Meals Served	127,143		$ 1,681,790	$ 704,039	24,846	$ 328,652	1
2	2	Food Purchase	Meals Served	127,143		76,931	0	24,846	15,034	2
3	3	Housekeeping	Time Spent	26,693		1,952,243	879,218	2,240	163,827	3
4	4	Laundry	Pounds of Laundry	36,623		690,906	89,119	5,380	101,496	4
5	5	Heat/Utilities	Square Feet	194,315		2,296,246	0	12,220	144,405	5
6	6	Plant	Square Feet	194,315		1,365,491	410,629	12,220	85,872	6
7	7	Cafeteria	FTEs Served	64,566		664,678	68,104	3,344	34,425	7
8	10	Nursing	Direct Hours	41,960		2,221,605	1,343,496	3,344	177,051	8
9	10	Medical Records	Time Spent	5,762		1,629,893	1,015,276	296	83,729	9
10	12	Social Services	Time Spent	8,708		432,069	244,195	1,790	88,815	10
11	15	Central Supply	Costed Req	1,358,678		951,506	222,779	15,514	10,865	11
12	15	Pharmacy	Costed Req	2,238,894		2,610,638	1,289,535	967	1,128	12
13	17	Administration	Revenue	368,265,031		13,808,237	6,237,471	3,385,024	126,923	13
14	22	Employee Benefits	Gross Salaries	44,157,383		10,193,214	0	1,211,618	279,688	14
15	26	Property Insurance	Square Feet	194,315		94,857	0	12,220	5,965	15
16	6	Maintenance	Costed Req	56,430		1,852,382	675,480	2,750	90,272	16
17	26	Malpractice Insurance	Revenue	368,265,031		5,239,201	0	3,385,024	48,158	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 47,761,887	$ 13,179,341		$ 1,786,305	25

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	IHFA		X	Refinance & Capital	Interest	1990	$ 27,209,221	$ 25,678,681	11/15/25	Floating	$ 6,341	1
2	IHFA		X	Refinance & Capital	Interest	1994	12,477,021	12,200,000	11/15/24	Floating	2,999	2
3	IHFA		X	Refinance & Capital	Interest	1999	28,900,000	27,551,380		Floating	6,818	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 68,586,242	$ 65,430,061			$ 16,158	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 68,586,242	$ 65,430,061			$ 16,158	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Gottlieb Memorial Hospital **#** 8008518 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ 0	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 0	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Gottlieb Memorial Hospital COUNTY Cook

FACILITY IDPH LICENSE NUMBER 8008518

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 0.00	$ 0.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,220 B. General Construction Type: Exterior Concrete Frame Reinforced Concrete Number of Stories 6

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Hospital & Parking	1,458,000	1961	$ 61,937	1
2					2
3	TOTALS	1,458,000		$ 61,937	3

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1961	1961	$ 1,789,885	$ 35,798	50	$ 35,798	$	$ 1,449,811	4
5			1982	1982	1,135,357	39,150	29	39,150		763,428	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1961	927,147		25	0		927,147	9
10	Building Improvements			1962	5,314	108	49	108		4,217	10
11	Building Improvements			1963	57,578	1,152	47-50	1,152		44,347	11
12	Building Improvements			1964	154	3	46	3		117	12
13	Building Improvements			1965	839,469	9,188	25-50	9,188		715,431	13
14	Building Improvements			1966	18,069	181	20-45	181		16,251	14
15	Building Improvements			1967	99,677	1,123	25-44	1,123		89,015	15
16	Building Improvements			1969	243,126	3,854	10-42	3,854		206,864	16
17	Building Improvements			1970	10,866		15-25	0		10,866	17
18	Building Improvements			1971	410,569	4,156	20-40	4,156		371,366	18
19	Building Improvements			1972	63,023	286	10-39	286		60,425	19
20	Building Improvements			1973	36,443		15-20	0		36,443	20
21	Building Improvements			1974	70,028	1,796	15-37	1,796		52,911	21
22	Building Improvements			1975	2,422		10	0		2,422	22
23	Building Improvements			1976	3,446,023	53,565	5-36	53,565		2,986,631	23
24	Building Improvements			1977	7,474,834	118,567	5-35	118,567		6,443,563	24
25	Building Improvements			1978	172,682	2,174	5-35	2,174		158,661	25
26	Building Improvements			1979	159,159	1,234	5-34	1,234		147,205	26
27	Building Improvements			1980	729,897	14,979	8-31	14,979		587,601	27
28	Building Improvements			1981	1,633,608	46,142	10-11	46,142		1,408,753	28
29	Building Improvements			1982	3,024,034	112,224	6-20	112,224		2,794,764	29
30	Building Improvements			1983	3,028,019	111,444	5-28	111,444		2,162,936	30
31	Building Improvements			1984	245,719	9,407	5-20	9,407		220,207	31
32	Building Improvements			1985	7,212,994	242,300	5-40	242,300		5,043,100	32
33	Building Improvements			1986	2,251,370	99,880	5-20	99,880		1,810,594	33
34	Building Improvements			1987	1,228,658	47,304	5-40	47,304		935,744	34
35	Building Improvements			1988	1,055,957	44,983	10-20	44,983		754,515	35
36	Building Improvements			1989	5,888,073	282,247	5-25	282,247		3,745,389	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvements	1990	$ 5,443,853	$ 269,266	5-20	$ 269,266	$	$ 3,039,302	37
38	Building Improvements	1991	2,702,153	135,258	10-20	135,258		1,378,524	38
39	Building Improvements	1992	2,395,627	119,134	2-20	119,134		1,139,484	39
40	Building Improvements	1993	1,601,815	79,040	2-20	79,040		679,563	40
41	Building Improvements	1994	2,930,128	146,652	20	146,652		1,102,939	41
42	Building Improvements	1995	4,798,468	236,879	20	236,879		1,549,459	42
43	Co-Generator Construction	1996	1,524,624	76,231	20	76,231		441,562	43
44	Emergency Water Main	1996	28,313	1,416	20	1,416		7,509	44
45	Absorption Chiller Construction	1996	558,317	27,916	20	27,916		158,956	45
46	Architecture Fees	1996	591,268	29,563	20	29,563		162,041	46
47	Hospital Signage	1996	9,074	454	20	454		2,589	47
48	Install Backflow Preventers	1996	23,735	1,187	20	1,187		6,748	48
49	Plumbing	1996	1,133	57	20	57		330	49
50	Remove Fiber Optics	1996	6,184	309	20	309		1,778	50
51	Emergency Power for Elevators	1996	7,800	390	20	390		2,210	51
52	POB Improvements	1996	475,382	23,769	20	23,769		133,987	52
53	Heating Work	1996	1,220	61	20	61		310	53
54	Construction Hospital Entrance	1996	118,241	5,912	20	5,912		30,305	54
55	Lightening Protection	1996	9,912	496	20	496		2,974	55
56	Remodeling Home Health	1996	39,853	1,993	20	1,993		11,371	56
57	Miscellaneous Improvements	1996	52,594	2,630	20	2,630		14,955	57
58	Warehouse	1996	25	1	20	1		7	58
59	Remodel Radiology	1996	2,052	103	20	103		590	59
60	Remodel Same Day Surgery	1996	30,902	1,545	20	1,545		8,137	60
61	Remodel ICU	1996	1,660	83	20	83		470	61
62	Remodel West Wing	1996	29,250	1,463	20	1,463		7,753	62
63	Remodel Medical Staff Office	1996	2,822	141	20	141		819	63
64	Slope Sink - Mechanical	1996	2,168	108	20	108		632	64
65	Remodel South Wing	1996	185,279	9,264	20	9,264		54,846	65
66	Remodel Operating Room	1996	25,040	1,252	20	1,252		6,723	66
67	Remodel Audiology	1996	1,500	75	20	75		450	67
68	Carpeting	1996	2,073	104	20	104		606	68
69	Cath Lab/Angio Addition	1996	600,588	30,029	20	30,029		157,253	69
70	TOTAL (lines 4 thru 69)		$ 67,463,206	$ 2,486,023		$ 2,486,023	$ 0	$ 44,055,908	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 67,463,206	$ 2,486,023		$ 2,486,023	$	$ 44,055,908	1
2	Cath Lab/Angio Addition	1997	29,968	1,498	20	1,498		7,301	2
3	Miscellaneous Improvements	1997	69,113	3,456	20	3,456		14,569	3
4	Architectural Fees	1997	241,107	12,055	20	12,055		54,499	4
5	Co-Generator Construction	1997	26,349	1,317	20	1,317		6,007	5
6	Data Processing Remodeling	1997	11,809	590	20	590		2,855	6
7	POB Improvements	1997	39,906	1,995	20	1,995		9,324	7
8	Operating Room Remodeling	1997	54,139	2,707	20	2,707		12,942	8
9	Hospital Entrance Construction	1997	2,102,804	105,140	20	105,140		489,050	9
10	2 West Remodeling	1997	8,210	411	20	411		1,849	10
11	Daycare Construction	1997	862,706	43,135	20	43,135		189,946	11
12	Audiology Remodeling	1997	637	32	20	32		146	12
13	TCT Suite Remodeling	1997	1,230	62	20	62		277	13
14	Radiology Remodeling	1997	50,684	2,534	20	2,534		10,413	14
15	GI Lab Remodeling	1997	715	36	20	36		158	15
16	Hospital Signage	1997	2,703	135	20	135		572	16
17	Labor Room Remodeling	1997	17,902	895	20	895		3,741	17
18	Retention Pond Installation	1997	51,168	2,558	20	2,558		10,857	18
19	POB Addition	1997	245,437	12,272	20	12,272		55,010	19
20	Locks	1997	926	46	20	46		220	20
21	Emergency Water Main	1997	2,900	145	20	145		677	21
22	Roof Repairs	1997	698	35	20	35		163	22
23	Same Day Surgery Remodeling	1997	2,761	138	20	138		672	23
24	3,4,5 South Remodeling	1997	14,778	739	20	739		3,329	24
25	Emergency Room Remodeling	1997	12,863	643	20	643		2,632	25
26	Main Lobby Remodeling	1997	293	15	20	15		62	26
27	Labor Room Remodeling	1998	218,240	10,912	20	10,912		41,432	27
28	Radiology Remodeling	1998	161,977	8,099	20	8,099		32,042	28
29	Emergency Room Remodeling	1998	2,680	134	20	134		536	29
30	Daycare Construction	1998	878,415	43,921	20	43,921		167,588	30
31	Main Lobby Remodeling	1998	940	47	20	47		188	31
32	Miscellaneous Improvements	1998	45,301	2,265	20	2,265		8,229	32
33	POB Improvements	1998	708,705	35,435	20	35,435		122,048	33
34	TOTAL (lines 1 thru 33)		$ 73,331,270	$ 2,779,426		$ 2,779,426	$ 0	$ 45,305,241	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 73,331,270	$ 2,779,426		$ 2,779,426	$	$ 45,305,241	1
2	Co-Generator Construction	1998	5,910	296	20	296		1,182	2
3	Hospital Signage	1998	49,712	2,486	20	2,486		7,814	3
4	POB Addition	1998	3,375,598	168,780	20	168,780		614,315	4
5	Hospital Entrance Construction	1998	38,075	1,904	20	1,904		7,057	5
6	Retention Pond	1998	8,952	448	20	448		1,750	6
7	Architecture Fees	1998	1,224,933	61,247	20	61,247		213,658	7
8	West Wing Remodeling	1998	347,379	17,369	20	17,369		65,180	8
9	HVAC Improvements	1998	370,685	18,534	20	18,534		66,293	9
10	Surgery Remodeling	1998	1,275	64	20	64		244	10
11	Physical Therapy	1998	205,829	10,291	20	10,291		32,627	11
12	Cath Lab/Angio Addition	1998	660	33	20	33		124	12
13	CT Suite Remodeling	1998	104,817	5,241	20	5,241		18,340	13
14	Telephone System Improvements	1998	41,722	2,086	20	2,086		7,649	14
15	Data Processing Remodeling	1998	6,781	339	20	339		1,187	15
16	Eye Center Remodeling	1998	741	37	20	37		117	16
17	ICU Remodeling	1998	27,500	1,375	20	1,375		4,297	17
18	Architecture Fees	1999	230,457	11,523	20	11,523		33,338	18
19	Back to Work Center	1999	802	40	20	40		120	19
20	Hospital Signage	1999	8,479	424	20	424		1,117	20
21	POB Improvements	1999	757,033	37,852	20	37,852		99,168	21
22	Contruction Hospital Entrance	1999	5,825	291	20	291		770	22
23	Remodeling - Physical Therapy	1999	446,529	22,326	20	22,326		62,827	23
24	Remodeling - Pharmacy	1999	1,152	58	20	58		138	24
25	Remodeling - Home Health	1999	25,475	1,274	20	1,274		2,757	25
26	Remodeling - Lab	1999	2,129	106	20	106		311	26
27	Remodeling - TCT Suite	1999	2,242	112	20	112		308	27
28	Remodeling - Radiology	1999	2,703	135	20	135		325	28
29	Remodeling - 6 South	1999	93,107	4,655	20	4,655		11,524	29
30	Remodeling - West Wing	1999	563,059	28,153	20	28,153		57,360	30
31	Remodeling - Emergency Room	1999	195,419	9,771	20	9,771		22,224	31
32	Integrated Medicine	1999	34,842	1,742	20	1,742		4,261	32
33	Co Generation System	1999	640	32	20	32		69	33
34	TOTAL (lines 1 thru 33)		$ 81,511,731	$ 3,188,449		$ 3,188,449	$ 0	$ 46,643,693	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 81,511,731	$ 3,188,449		$ 3,188,449	$	$ 46,643,693	1
2	Miscellaneous Improvements	1999	2,397	120	20	120		298	2
3	HVAC	1999	4,460	223	20	223		620	3
4	Daycare Construction	1999	24,254	1,213	20	1,213		3,078	4
5	Fire Alarm System	1999	97,371	4,869	20	4,869		12,092	5
6	POB Addition	1999	1,277,351	63,868	20	63,868		165,902	6
7	Warehouse	1999	7,126	356	20	356		932	7
8	Master Plan Fees	1999	355,950	17,798	20	17,798		33,139	8
9	Master Plan Fees	2000	5,028,360	227,194	20	227,194		280,023	9
10	Miscellaneous Improvements	2000	25,154	1,258	20	1,258		1,527	10
11	Fire Alarms	2000	12,000	600	20	600		1,117	11
12	Remodel Labor Room	2000	900	45	20	45		64	12
13	Remodel Radiology	2000	6,504	325	20	325		539	13
14	Remodel Surgery	2000	8,595	430	20	430		630	14
15	Remodel Emergency Room	2000	444,702	22,235	20	22,235		36,225	15
16	Remodel 6 South	2000	120,201	6,010	20	6,010		7,558	16
17	Remodel Physical Therapy	2000	10	0	20	0		1	17
18	Remodel West Wing	2000	4,273	213	20	213		371	18
19	Warehouse	2000	9,357	468	20	468		858	19
20	POB Improvements	2000	326,166	16,308	20	16,308		27,311	20
21	Medical Staff Office	2000	3,118	156	20	156		182	21
22	Remodel South Wing	2000	52,177	2,609	20	2,609		2,860	22
23	POB Addition	2000	89,206	4,460	20	4,460		8,316	23
24	Remodel MRI	2000	840	42	20	42		70	24
25	Architecture Fees	2000	77,316	3,866	20	3,866		4,716	25
26	Master Plan Fees	2001	3,060,802	17,062	20	17,062		17,062	26
27	Miscellaneous Improvements	2001	87,545	998	20	998		998	27
28	Fire Alarms	2001	7,871	361	20	361		361	28
29	Remodel Radiology	2001	25,457	215	20	215		215	29
30	Remodel Surgery	2001	51,757	436	20	436		436	30
31	Remodel Emergency Room	2001	88,199	3,135	20	3,135		3,135	31
32	Remodel Physical Therapy	2001	3,130	78	20	78		78	32
33	Remodel West Wing	2001	38,517	388	20	388		388	33
34	TOTAL (lines 1 thru 33)		$ 92,852,795	$ 3,585,787		$ 3,585,787	$ 0	$ 47,254,794	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 92,852,795	$ 3,585,787		$ 3,585,787	$	$ 47,254,794	1
2	Remodel Pharmacy	2001	23,294	166	20	166		166	2
3	POB Improvements	2001	286,818	3,806	20	3,806		3,806	3
4	Medical Staff Office	2001	360	6	20	6		6	4
5	Remodel South Wing	2001	257,386	8,590	20	8,590		8,590	5
6	POB Addition	2001	11,127	46	20	46		46	6
7	Remodel Cafeteria	2001	29,986	315	20	315		315	7
8	Architecture Fees	2001	272,218	8,677	20	8,677		8,677	8
9	Adult Day Care	2001	41,648	1,489	20	1,489		1,489	9
10	Coffee Shop	2001	79,411	569	20	569		569	10
11	PHO Project	2001	24,282	212	20	212		212	11
12	Home Health	2001	35,700	446	20	446		446	12
13	Absorbtion Machine	2001	23,221	288	20	288		288	13
14	HVAC	2001	18,771	235	20	235		235	14
15	Roof Repairs	2001	10,385	43	20	43		43	15
16	Construction Hospital Entrance	2001	1,226	15	20	15		15	16
17	Land Improvements Total Hospital		4,469,944	95,024	5-25	95,024		3,769,651	17
18	Less Improvements Allocated to Other								18
19	Areas of Hospital based upon square footage		(92,246,784)	(3,472,627)		(3,472,627)		(47,838,347)	19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,191,786	$ 233,090		$ 233,090	$ 0	$ 3,211,003	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 53,497	$ 6,942	$ 6,942	$ 0	3-10	$ 29,171	71
72	Current Year Purchases	29,603	3,906	3,906	0	3-7	3,906	72
73	Fully Depreciated Assets	3,035			0	11	3,035	73
74					0			74
75	TOTALS	$ 86,135	$ 10,847	$ 10,847	$ 0		$ 36,112	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,339,858	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 243,937	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 243,937	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,247,115	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/01 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 14,845,484	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,451,645)	18,586,716		3
4	Supply Inventory (priced at cost)	2,215,460		4
5	Short-Term Investments	21,001,301		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	423,750		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Affiliates	4,671,834		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 61,744,545	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	87,956,162		12
13	Land	4,293,071		13
14	Buildings, at Historical Cost	98,438,360		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	47,849,149		16
17	Accumulated Depreciation (book methods)	(87,790,753)		17
18	Deferred Charges	4,322,040		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Inv In PHO, Self Ins	2,481,794		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 157,549,823	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 219,294,368	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,648,376	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	5,612,507		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Exp/Bond Payable	5,358,423		36
37	Third Party Settlement	8,526,923		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 23,146,229	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	64,414,491		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Reserve for Self Insurance	6,736,800		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 71,151,291	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 94,297,520	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 124,996,848	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 219,294,368	$ 0	48

***(See instructions.)**

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 132,454,397	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 132,454,397	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,549,414	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Forgive amt due from GHR & GHS**	(13,006,963)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (7,457,549)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 124,996,848	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 368,265,031	1
2	Discounts and Allowances for all Levels	(258,190,615)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 110,074,416	3
	B. Ancillary Revenue		
4	Day Care	536,919	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 536,919	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	419,821	14
15	Telephone, Television and Radio	7,070	15
16	Rental of Facility Space	383,754	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,349,697	19
20	Radiology and X-Ray	16,503	20
21	Other Medical Services	38,207	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,215,052	23
	D. Non-Operating Revenue		
24	Contributions	680,860	24
25	Interest and Other Investment Income***	2,956,073	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,636,933	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Non Operating Revenue	(7,779)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (7,779)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 116,455,541	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	109,148,127	31
32	Health Care		32
33	General Administration		33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Non Recurring Item	1,758,000	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 110,906,127	40
41	**Income before Income Taxes (line 30 minus line 40)****	5,549,414	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 5,549,414	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,873	2,097	$ 65,273	$ 31.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	19,512	21,897	602,248	27.50	3
4	Licensed Practical Nurses	7,882	9,170	147,001	16.03	4
5	Nurse Aides & Orderlies	23,339	25,672	265,909	10.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,922	2,089	25,371	12.15	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,981	2,169	40,081	18.48	22
23	Office Manager					23
24	Clerical	4,656	5,093	59,788	11.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	61,165	68,187	$ 1,205,671 *	$ 17.68	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	147	$ 5,947		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	147	$ 5,947		53

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$

TOTAL (agree to Schedule V, line 17, col. 1) $

(List each licensed administrator separately.)

B. Administrative - Other

Description	Amount
	$

TOTAL (agree to Schedule V, line 17, col. 3) $

(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
		$

TOTAL (agree to Schedule V, line 19, column 3) $

(If total legal fees exceed $2500 attach copy of invoices.)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	

TOTAL (agree to Schedule V, line 22, col.8) $

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$

TOTAL $

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )

TOTAL (agree to Sch. V, line 20, col. 8) $

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )

TOTAL (agree to Sch. V, line 24, col. 8) $

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
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18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Gottlieb Memorial Hospital # 8008518 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 0
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 34,425 Has any meal income been offset against related costs? No Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ernst and Young The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not available at this time

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.